DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 7489 (04/08)

STATE OF WISCONSIN
Chapter HFS110 Wis. Admin. Code
(608) 266-1568

EMERGENCY MEDICAL SERVICES (EMS)
PATIENT CARE WORKSHEET

This form is for use by ambulance service providers who are unable to immediately comply with Chapters HFS 110, 111, 112 and 113, Wis. Admin. Code as they apply to documentation of ambulance runs by completing and providing patient care information to the receiving facility when the patient is delivered to the facility. Per the above administrative rules, this form becomes part of the patient's medical record.

INSTRUCTIONS: Print legibly. Complete all sections of this worksheet. A copy of this worksheet or the ambulance run report must be completed and left with the receiving facility when the patient is delivered. This form does not constitute the official ambulance run report / patient care report.

Ambulance Service: _____ **Run Number:** _____

Incident Date: _____ **Incident Location:** _____

Patient Name: _____

DOB _____ **Age:** _____ **Sex:** ☐ Male ☐ Female **Weight:** _____

PatientAddress: _____

Chief Complaint: _____

Physician: _____

NOI / MOI: _____

GCS: Eyes 4-1 _____ Speech 5-1 _____ Motor 6-1 _____ Total _____

LOC: Alert X (Check one) ☐ 1 ☐ 2 ☐ 3 (Check all that apply) ☐ Respond to verbal ☐ Respond to pain ☐ Unresponsive

Time	BP	Pulse Rate / Quality	Respiratory Rate	Oximetry	Glucometer	EKG Monitor

Skin: (Check all that apply) ☐ Warm ☐ Dry ☐ Moist ☐ Cold ☐ Flush ☐ Pale

Eyes: (Check all that apply) ☐ PERRL ☐ Constricted ☐ Dilated ☐ Non-reactive

O_2 Given: ☐ Yes ☐ No **Rate of flow:** _____ (Check one) ☐ Mask ☐ cannula ☐ BVM

Allergies: _____ **Last Oral Intake:** _____

Medications: _____

Past Medical History (Check all that apply) ☐ Cardiac ☐ CHF ☐ Hypertension ☐ Seizure ☐ Diabetes ☐ COPD ☐ Asthma

Other _____

Treatment: _____

_____

Response to Treatment: _____

CPR: ☐ Yes ☐ No **Time Started:** _____ **Defib/Shock:** ☐ Yes ☐ No

Return of Pulse? ☐ Yes ☐ No Rate _____ **Respirations?** ☐ Yes ☐ No Rate _____

Squad Member(s): _____

THIS FORM DOES NOT REPLACE THE OFFICIAL ABULANCE RUN REPORT OR THE PATIENT CARE REPORT